Province of British Columbia
Ministry of Health

THE
PREVENTION AND HANDLING
OF
UNWANTED PREGNANCIES

MINISTRY OF HEALTH, 1987

POLICY REVIEW

PREVENTION AND HANDLING OF UNWANTED PREGNANCIES

Ministry of Health
March 16, 1987

EXECUTIVE OVERVIEW

PREVENTION AND HANDLING OF UNWANTED PREGNANCIES

PURPOSE

The Ministry of Health undertook this policy review following a request from the Premier in late December of 1986. The purposes of the review are:

1. To review the way unwanted pregnancies are currently handled in British Columbia.

2. To answer a number of questions about the handling of abortions in British Columbia, including whether or not these procedures are performed in compliance with the Criminal Code.

3. To identify any steps the Provincial Government could take to improve its overall approach to the problem of unwanted pregnancy and minimize the number of therapeutic abortions.

METHODOLOGY

The preparation of this report has involved several major tasks: (1) collection and analysis of abortion statistics in British Columbia, Canada, and other countries; (2) a review of abortion studies and policy initiatives in other jurisdictions; (3) a survey of British Columbia hospitals to ascertain existing abortion policies and procedures (this included visits by expert consultants to selected hospitals); (4) a review of support services available to women who continue unplanned pregnancies to term; (5) consultation with the Ministry of Social Services and Housing about adoption policies; and (6) consultation with the Ministry of Education about educational programs designed to minimize the number of unwanted pregnancies.

FINDINGS RESPECTING ABORTION PRACTICES

The Ministry's review of abortion statistics and hospital procedures produced the following findings:

1. **Numbers**: Preliminary reports indicate that 11,507 therapeutic abortions were performed in British Columbia in 1986, a 1.7 percent increase over 1985. Prior to this slight increase, the number of abortions had been declining steadily for several years.

2. **Rates**: British Columbia's abortion rate, at 26.1 per 100 live births in 1985, is the highest in Canada and considerably above the Canadian average of 16.2. There are no obvious medical or legal reasons why this is so. On the other hand, British Columbia's abortion rates are well below those of Washington, Oregon, and California.

3. Characteristics of Women: Almost four out of five (79%) of the women having abortions have never been married or are no longer married. Most (63%) have no children. A majority (57%) are in their twenties. About one in five (21%) is a teenager, and about an equal number (22%) are aged 30 or over. The overall decline in abortion rates during the last several years has occurred mainly in the younger age groups, especially teenagers.

5. Legality: All hospitals and therapeutic abortion committees in British Columbia are complying with the requirements of the Criminal Code of Canada.

6. Approval Rates: In 1986, therapeutic abortion committees in British Columbia approved the vast majority of applications they received.

7. Approval Criteria: In deciding whether or not an abortion should be approved on the legal grounds that continuation of the pregnancy "would or would be likely to endanger" the "life or health" of the woman, most therapeutic abortion committees use the World Health Organization definition of "health": "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." But a few therapeutic abortion committees interpret the Criminal Code provisions more narrowly.

8. Reasons for Abortions: A large majority of abortions are apparently performed to safeguard psychological or social health rather than physical health.

9. Abortion and Family Planning: The majority of women obtaining an abortion in British Columbia are using the abortion to terminate a single unplanned pregnancy outside of marriage, and hence do not appear to be relying on abortion as their primary, ongoing method of family planning.

FINDINGS RESPECTING CURRENT ARRANGEMENTS FOR THE CONTINUATION AND PREVENTION OF UNWANTED PREGNANCIES

The Ministry also reviewed the current status of policies and programs dealing with the alternatives to abortion, i.e.: (1) a woman's continuation of an unwanted pregnancy in order to keep and rear the child herself or relinquish it for adoption; and (2) avoidance of unwanted pregnancy in the first place. This review produced the following findings:

1. General: Existing public policies and programs do provide support to women who decide to continue unwanted pregnancies to term, but there are several apparent deficiencies in these policies and programs.

2. Financial Assistance: Financial assistance rates for eligible single parents have increased little since 1982. In addition, it can be difficult to find day care for very young children, and the current day care subsidies normally fall short of actual expenses.

3. Adoption Trends: The number of healthy infants put up for adoption to non-relatives has dropped dramatically in the last fifteen years. During the 1960s, it was not possible to find homes for all of the children relinquished for adoption but today the Ministry of Social Services and Housing maintains a long waiting list of families seeking to adopt healthy infants.

4. Adoption Procedures: Adoption procedures may not be sufficiently well known among physicians, counselling agencies, school counsellors, or even government staff. In addition, the existing arrangements do not seem to be attractive to most women.

5. Prevention of Unwanted Pregnancy: British Columbia does not have a coordinated program to prevent unwanted pregnancy. Instead, individual government programs, along with voluntary groups and local agencies, address specific aspects of the issue on an ad hoc basis.

POLICY NEEDS

The findings described above suggest that more needs to be done in order to minimize the number of abortions. Compared to other Canadian provinces, British Columbia's abortion rate is high. At the same time, alternatives to abortion are not as available as they could be, and the supply of abortion services varies greatly from region to region due to the differing approval criteria used by therapeutic abortion committees.

RECOMMENDATIONS

The Ministry examined a wide variety of possible options for further reducing the demand for abortions and for achieving a better regulation of supply. Each of these options was analysed in terms of probable effectiveness, legal and financial feasibility, and social and medical implications.

On the basis of these criteria, options involving strong restrictive action to limit or reduce the overall supply of abortion services are not recommended. The responsibility for abortion law lies within federal jursidiction, and thus any steps taken by the provincial government with the predominant effect of making the federal law more restrictive would be beyond the authority of the provincial legislature and hence subject to legal challenge and invalidation. The province does have responsibility for medical

insurance for abortions, and hence could eliminate medical coverage for abortions except where it deems them to meet a specific definition of "medical necessity." However, such action is not recommended because it would not necessarily reduce the number of abortions, and could jeopardize federal cost sharing and discriminate against poorer women.

It is recommended that the Government take a number of positive initiatives to help reduce the demand for abortions and achieve a better regulation of supply.

In order to reduce the demand for abortions, the Government should take steps to support the alternatives. Specifically:

1. <u>Develop better educational and contraceptive programs to prevent unwanted pregnancy</u>.

   In addition to family life education programs in all schools (an initiative already being planned), this should involve a network of convenient family planning clinics throughout the province.

   - Such clinics could be established in conjunction with public health units (this would require an increase in staffing, including physicians, nurses, and social workers).

   - In other communities, the Ministry of Health could provide funding to private organizations.

   Programs to prevent unwanted pregnancy appear to be the most cost effective approach available to the Province and should therefore receive the highest priority and the largest budget allocation.

2. <u>Promote greater awareness of the alternatives to abortion</u>.

   This should involve:

   (a) An information campaign aimed at providing physicians, government staff, clergymen, and private organizations with a good understanding of all of the options and services currently available to women with unwanted pregnancies.

   (b) The development of incentives to encourage doctors to offer extended counselling (or to make appropriate referrals for extended counselling) to women experiencing unwanted pregnancies.

   - Such counselling should deal with: (i) alternatives to abortion, in the case of women who currently have unwanted

pregnancies, and (ii) family planning and contraception, in the case of women who have recently had an abortion.

- To give the subject prominence in the minds of physicians, incentives might take the form of a special fee item.

- In addition, hospitals could be asked to encourage abortion patients to arrange follow-up visits with their family physicians, gynecologists, or public health units soon after the procedure.

(c) Government funding for pregnancy counselling centres operated by public health units or by private organizations.

(d) The development of coordinating/case management services to help women understand and access alternatives to abortion, including adoption and financial/emotional support services.

- This might involve toll-free "hot lines" for women in rural areas.

3. Where possible, offer additional assistance to women continuing their pregnancies.

On an immediate basis, this could involve:

(a) Improved access to special programs to enable pregnant teenagers to continue their schooling.

(b) Better enforcement of maintenance payments from fathers.

(c) The provision of additional financial assistance for privately operated homes for unwed mothers, if there is a demonstrated demand for such services; or, alternatively, the development of pilot projects to test out innovative forms of residential support for expectant mothers--e.g. sheltered independent apartments.

On a longer term basis, this could involve increases in social assistance rates and day care subsidies, as well as improvement of adoption procedures.

In order to avoid inconsistency in the application of the abortion law, the Government should take the following steps:

4. Establish a blue ribbon panel of medical and ethical experts to develop voluntary, public guidelines for hospital boards and therapeutic abortion committees.

These guidelines should include a definition of the phrase "would or would be likely to endanger her life or health."

Ideally, the guidelines should be developed by a "Special Panel on Ethical Issues in Health Care"--a body which could also address issues such as euthanasia, genetic engineering, and the use of human embryonic tissue for scientific purposes. This panel could be comprised of physicians, clergy, ethicists, lawyers, health administrators, women's groups, and others.

5. Institute regular auditing of the activities of therapeutic abortion committees.

6. Urge the Federal Government to review and amend the Criminal Code provisions relating to abortion.

   The Province should suggest that the Federal Government (a) clarify conditions under which abortions may be permitted, by defining the phrase "would or would be likely to endanger her life or health"; and (b) reexamine the concept of "therapeutic abortion committees," to determine whether or not these bodies are performing any useful function, or whether some better mechanism for overseeing the approval of abortions could be developed.

Schedule A outlines the estimated 1987/88 costs of implementing these recommendations.

SCHEDULE A

PREVENTION AND HANDLING OF UNWANTED PREGNANCIES

1987/88 BUDGET REQUIREMENTS

1.	Recommendation #1: Educational and Contraceptive Programs	
	a. Needs assessment to determine current service gaps	$50,000
	b. Staffing costs for public health units and/or funded agencies	$630,000
	c. Materials and supplies	$150,000
	d. Ministry coordinator	$45,000
2.	Recommendation #2: Promote Awareness of Alternatives to Abortion	
	a. Information program for health and social services professionals; and public media campaign	$300,000
	b. Toll-free information and referral line	$150,000
3.	Recommendation #3: Additional Assistance for Pregnant Women	
	Will include innovative pilot projects designed to provide services identified as necessary by needs assessment and community groups (e.g. sheltered independent apartments)	$500,000
4.	Recommendation #4: Blue Ribbon Panel	
	Travel expenses and per diems	$20,000
5.	Recommendation #5: Audit Therapeutic Abortion Committees	nil
6.	Recommendation #6: Urge Federal Government to Amend Criminal Code	nil
TOTAL		$1,845,000

POLICY REVIEW

PREVENTION AND HANDLING OF UNWANTED PREGNANCIES

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1.0 PURPOSE

This paper has the following purposes:

1. To review the way unwanted pregnancies are currently handled in British Columbia.

2. To answer a number of questions about the handling of abortions in British Columbia, including whether or not these procedures are performed in compliance with the Criminal Code.

3. To identify any steps the Provincial Government could take to improve its overall approach to the problem of unwanted pregnancy and minimize the number of therapeutic abortions.

2.0 BACKGROUND

2.1 Origins of Review

The Ministry of Health undertook this review following a request from the Premier in late December of 1986. The Premier asked the Ministry to determine if existing abortion laws are being upheld in the Province's hospitals. He also requested that the review examine the status of alternatives to abortion, including adoption and the avoidance of unwanted pregnancy.

2.2 Methodology of Review

In order to develop practical recommendations for consideration by the Government, the Ministry has attempted to approach this issue in a careful and systematic fashion.

The next part of this paper, section 3.0, outlines the Government's broad goals with respect to unwanted pregnancies--i.e. what, ideally, it would like public policies in this area to achieve. Sections 4.0 and 5.0 then review the actual status of public policies and programs at the present time. Based on this analysis of the status quo, section 6.0 identifies areas of apparent policy needs--i.e. areas where the current public policies or programs are inappropriate or inadequate to achieve the stated policy goals. Section 6.0 also discusses some of the broad practical limits on the options available to the Province to rectify existing weaknesses. Sections 7.0 and 8.0 analyze the advantages and disadvantages of specific options the Government could consider to improve its approach to unwanted pregnancy. Section 9.0 contains the Ministry's recommendations.

The preparation of this report has involved several major tasks: (1) collection and analysis of abortion statistics; (2) a review of abortion studies and policy initiatives in other jurisdictions; (3) a survey of British Columbia hospitals to ascertain existing abortion policies and procedures (this included visits by expert consultants to selected hospitals); (4) a review of support services available to women who continue unplanned pregnancies to term; (5) consultation with the Ministry of Social Services and Housing about adoption policies; and (6) consultation with the Ministry of Education about educational programs designed to minimize the number of unwanted pregnancies.

2.3 Limitations of Review

The review attempts to provide answers to the specific questions raised by the Premier, and identify general policy directions warranting consideration. However, the development of specific new policies and programs will in most cases require considerable additional work by the Ministry or Ministries responsible.

3.0 POLICY GOALS

Unwanted pregancies represent an extremely difficult situation--one for which there is rarely a "good" solution for all involved. Because they can exact enormous human costs (as well as significant financial costs), it is vital to ensure that public policies are dealing with unwanted pregnancies in the most effective and compassionate manner possible.

Principally because of the moral and ethical dilemmas it poses, abortion is a particularly difficult issue. Although consensus on abortion policy often seems elusive, our society does generally appear to feel that abortion is the least satisfactory means of dealing with unwanted pregnancies; that abortion is an option which should be exercised only when all of the alternatives for dealing with the situation have been explored and it has been established without doubt that abortion is the only means of adequately protecting the life or health of the woman.

From this basic premise, it is possible to identify the broad goals and priorities that should guide policies or programs dealing with unwanted pregnancy and abortion. These are:

1. To minimize the demand for abortion by supporting the alternatives:

   a. to prevent unwanted pregnancies from occurring in the first place;
   b. to ensure that a variety of alternatives to abortion are readily available if unwanted pregnancy does occur, and that these alternatives are well known and fully explored in all cases.

2. To prevent either an oversupply or an undersupply of abortion services:

   a. to ensure that abortions are not approved routinely, and that therapeutic abortion committees provide the "sober second look" intended by Parliament;

   b. to ensure that necessary thereapeutic abortions are available, and are handled as near as possible to the woman's place of residence, thus minimizing the human and financial cost to her and preventing excessive workloads for physicians and hospitals in other localities.

4.0 FINDINGS RESPECTING CURRENT ABORTION PRACTICES IN BRITISH COLUMBIA

4.1 Introduction

This section summarizes the major findings of the Ministry of Health's review of abortion practices in British Columbia. It is based on: data published by Statistics Canada; a survey of all hospitals with therapeutic abortion committees; visits to twelve hospitals in different regions of the Province; and reviews of previous abortion studies and the existing research literature.

The findings are presented in the form of answers to the key questions which have been raised about abortions in British Columbia.

4.2 Abortion Rates

How many abortions are performed in British Columbia? How do these figures compare with those of other jurisdictions, and what accounts for any differences?

Numbers and trends

Preliminary reporting indicates that approximately 11,507 therapeutic abortions were performed in British Columbia's hospitals in 1986. This figure represents a 1.7 percent increase over the 1985 total of 11,316. Prior to this slight increase, the annual number of abortions, as well as the abortion "rates" (i.e. abortions per 1000 women aged 15-44; and abortions per 100 live births) had been declining steadily for several years. In 1978, there were 33.5 abortions for every 100 live births, but by 1985 this had declined to 26.1.

Comparison with other provinces and countries

Although British Columbia's abortion rate has decreased significantly during the past several years, the 1985 rate of 26.1 per 100 live births was the highest of any province in Canada. Ontario was next, at 20.7; and Alberta followed, with 14.9. The Canadian average was 16.2, and the province with the lowest rate was Prince Edward Island, with 0.5.

Examples of countries with higher abortion rates than British Columbia for their own residents are the United States (including the individual western states of Washington, Oregon, and California), Denmark, Japan and Italy. Countries with lower abortion rates for their own residents include England and Wales, West Germany, the Netherlands, and New Zealand.

Reasons for interprovincial differences

The reasons for British Columbia's high abortion rate compared to other Canadian provinces are not completely clear. Part of the difference is unquestionably due to data problems: figures from Quebec, for example, do not include abortions performed in the free standing abortion clinics which continue to operate in that Province; and those from the Maritimes do not include the relatively larger number of women there who obtain abortions outside their home provinces.*

Nevertheless, British Columbia does have a high abortion rate compared to other provinces, and there are no obvious legal or medical reasons why this should be so. Under the Criminal Code of Canada, therapeutic abortions in this country are permitted only where a hospital's therapeutic abortion committee certifies that continuation of the pregnancy would, or would likely, endanger the life or health of the pregnant woman. There is no reason to believe that women in British Columbia are less healthy, i.e. less capable of safely bearing children, than women elsewhere in Canada.

The number of abortions performed in any jurisdiction is a function of demand and supply. The higher number of abortions in British Columbia must be attributable to differences in one or both of these factors:

- Demand: Women in British Columbia may have a higher rate of unwanted pregnancy, and/or they (and their physicians) may have a different perception of need, i.e. of danger to health, and therefore may be submitting more applications.

- Supply: Therapeutic abortion committees in British Columbia may generally be using a wider definition of "health," and/or there may be a greater availability of hospitals capable of performing abortions and willing to do so.

4.3 Characteristics of Women Having Abortions

What are the demographic characteristics of the women having abortions in British Columbia?

Overall profile

Almost four out of five (79 percent) of the women having abortions have never been married or are no longer married. Most (63 percent)

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*Hospitals in Prince Edward Island have all chosen not to establish therapeutic abortion committees. Only one hospital in Newfoundland has a therapeutic abortion committee, and no abortions are currently performed there because the one doctor willing to perform abortions went on extended sick leave several months ago.

have no children. A majority (57 percent) are in their twenties. About one in five (21 percent) is a teenager, and about an equal number (22 percent) are aged 30 or over.

Trends by age group

The recent decline in overall abortion rates has occurred mainly in the younger age groups. The abortion rate per 1000 females aged 15-19 dropped from 28.6 in 1980 to 22.1 in 1985; and for females aged 20-24 it dropped from 32.4 to 28.8 in the same period. In contrast, the rates for women in older age groups declined only marginally. Nevertheless, the 20-24 cohort still has the highest rate, and the 15-19 cohort has the second highest rate.

The greatest disparity between British Columbia and other provinces is among women 25-29; they have an abortion rate almost twice the national average. The disparity between British Columbia and other provinces is smaller among teenagers. Moreover, the decline in the abortion rate has been most pronounced among those who are still in school or have recently graduated. Since the rate of live births to teenagers has also declined significantly, it appears that the current group of teenagers are having more success than their predecessors at avoiding unwanted pregnancy.

4.4 Legality of Abortions

Are abortions in British Columbia being performed in compliance with the existing abortion laws?

Allocation of authority under existing law

The Province of British Columbia has no legislative role with respect to abortion. Abortion is a Federal matter, governed by the Criminal Code of Canada. Section 251 of the Code permits the board of management of an accredited or approved hospital to appoint a therapeutic abortion committee. This hospital committee, composed of not fewer than three medical practitioners, then makes the actual decisions about abortions in that hospital. The committee has the power to authorize an abortion where, in its opinion, the continuation of the pregnancy would, or would likely, endanger the life or health of the pregnant woman.

Practices of British Columbia hospitals

In order to determine whether or not hospitals and therapeutic abortion committees in British Columbia are complying fully with the various requirements and procedures laid out in the Criminal Code, the Ministry conducted a survey of all hospitals with therapeutic abortion committees. In addition, a Ministry review team conducted on-site visits and interviews at twelve hospitals--hospitals which, in 1985, performed 86 percent of the Province's abortions.

Although the review team found some minor procedural irregularities associated with the operation of a few therapeutic abortion committees, all of the hospitals reviewed were complying fully with all of the requirements of the Criminal Code. They all had duly constituted therapeutic abortion committees with a minimum membership of three physicians. There was no evidence of doctors who perform abortions sitting on any therapeutic abortion committee, and all the committees issued appropriate abortion certificates.

Court records

The Ministry of Attorney General reports that in 1985, the latest year for which statistics are available, no charges were laid under section 251 of the Criminal Code for illegally performed abortions.

4.5 Functioning of Therapeutic Abortion Committees

Do therapeutic abortion committees play a useful role in determining whether or not a pregnancy is endangering the life or health of a woman, or do they simply "rubber stamp" the decision already taken by the woman and her physician?

Numbers of applications refused

To answer the above question, the Ministry conducted a telephone survey of the 52 hospitals in British Columbia with therapeutic abortion committees. The survey showed that, in 1986, abortions were approved and performed for the vast majority of women whose applications came before therapeutic abortion committees. Out of a total of 12,234 applications, 11,507, or 94 percent, resulted in abortions. The remaining 6 percent of applications were either rejected, or were submitted on behalf of women who subsequently decided not to have a therapeutic abortion or who experienced a spontaneous abortion. We do not know how many of the rejected applications were subsequently re-submitted (accompanied by better documentation or justification) and finally approved, either at the same hospital or at a different hospital.

The ratio of applications approved, to abortions performed, varied from a high of 100 percent at some hospitals to a low of 66 percent.

Reasons for low rejection rate

The Ministry's review team feels that the low rejection rate of most therapeutic abortion committees results from the fact that the doctors submitting applications to a particular committee are generally familiar with the approval guidelines used by that committee. In other words, by "pre-screening" applications, the referring doctors minimize the numbers which are formally rejected.

Some hospitals which are situated in major communities in the Lower Mainland and which have therapeutic abortion committees, but which are known by the local medical communities to use restrictive approval criteria, received no applications at all--and hence refused no applications--in 1986. Substantial numbers of women from these communities obtained abortions at hospitals in Vancouver.

The following considerations may also contribute to the low rejection rate:

- As the Federal Government's 1977 Badgley Report noted, physicians sitting on therapeutic abortion committees are reluctant to second guess the judgement of a medical colleage who has submitted an application in good faith--especially when they lack his first hand knowledge of the patient's circumstances.

- In some hospitals, the magnitude of the workload may make detailed review of individual cases unrealistic. For example, in one large hospital, the therapeutic abortion committee must make decisions on up to 120 applications at its weekly meeting--a meeting which lasts one or two hours.

Reasons for rejection of some applications

The reasons for which some applications are rejected vary from hospital to hospital, depending on the particular therapeutic abortion committee's criteria for approval (discussed below). Most committees will not approve an abortion if they consider that the pregnancy is too far advanced. The latest that most committees will approve abortions is 20 weeks of gestation.

Physicians' opinions of therapeutic abortion committees

Physicians, including those who sit on therapeutic abortion committees, are generally doubtful about the value of the committees. This finding is similar to those of other studies. For example, the Report on Therapeutic Abortion Services in Ontario, released on January 27, 1987, found that "close to 95 percent" of 150 physicians surveyed in that province felt that therapeutic abortion committees serve no useful purpose. Moreover, the Canadian Medical Association adopted a resolution in 1971 (reaffirmed in 1985), calling for amendment of the Criminal Code to delete any reference to therapeutic abortion committees and hence to leave the question of abortion to individual women and their physicians.

4.6 Reasons for Abortions

What are the most common justifications for the abortions being performed in British Columbia? How are therapeutic abortion committees interpreting the provisions of the Criminal Code, particularly the terms "health" and "would or would be likely to endanger"?

Approval criteria used by hospitals

To obtain information about the approval criteria used by therapeutic abortion committees in British Columbia, an expert review team interviewed the committees at six selected hospitals. In interpreting the Criminal Code provision "would or would be likely to endanger her life or health," most of the committees use the World Health Organization definition of "health": "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Some hospitals, however, have a more restrictive approach. At one, the board of trustees has instructed the therapeutic abortion committee that "would be likely to endanger her...health" must be interpreted to mean that there is a strong probability that the woman's health would be seriously jeopardized. The board has also altered the membership of the therapeutic abortion committee to include three physicians committed to limiting the number of abortions, and has introduced some fairly rigorous procedural requirements which must be satisfied before an abortion is approved. For example, a woman requesting an abortion must complete a "confirmation of informed consent" form containing references to: (1) the provisions of the Criminal Code; (2) alternatives to abortion, such as adoption; (3) the chronology of pre-natal development; and (4) possible complications of the abortion procedure.

Where hospital boards attempt to introduce more restrictive policies, the medical staff of the hospital generally regards this as an inappropriate intrusion by "laymen" into matters of medical judgement. At some hospitals, this has seriously impaired the working relationship of the boards of trustees and medical staffs.

Almost all abortion committees have rules respecting maximum length of gestation. This suggests that the majority of committees do not necessarily equate demand and need, or view "need" as an absolute condition. At some point (usually 20 weeks), the committees see the risks of continued pregnancy as being counterbalanced by the heightened risks of late abortion and perhaps also by the interests of the increasingly viable fetus.

Types of health risks leading to abortions

Given the fairly broad criteria accepted by most therapeutic abortion committees, a majority of abortions are apparently performed to safeguard psychological or social, rather than physical, health. This is consistent with the findings of the Badgley Report, which established that "reactive depression" was the most common reason for abortions.

4.7 Abortion and Birth Control

Are some women using abortions as a form of birth control/family planning?

Clarification of issue

All abortions represent a form of "birth control" in the sense that they are preventing births which are either dangerous or unwanted.

A minority of abortions are completely unrelated to "family planning" because they are terminating pregnancies which were wanted and planned but have become a danger to the woman's health. However, the majority clearly do represent a form of "family planning" in the sense that they are ending pregnancies which were unintended and never wanted, and should theoretically have been avoidable if contraceptive practices were foolproof.

The key questions about most abortions are thus not whether they are a form of family planning--which they are--but rather whether they are (1) the primary means of family planning, and/or (2) the primary, ongoing means of family planning. In other words, are abortions used in lieu of contraception or as a backstop to contraceptive failure? If they are used in lieu of contraception, is this an accepted practice or an infrequent mistake?

Use of contraception

We do not have any data on the use of contraception by those obtaining abortions in British Columbia. However, studies from other jurisidictions indicate consistently that sizable percentages of abortion patients were not using contraception, or were not using it consistently, at the time they became pregnant. In addition, a 1985 study found that about 5 percent of sexually active women in Canada use no method of contraception, even though they do not wish to become pregnant. While not conclusive, these figures do suggest that at least some of the women receiving abortions in British Columbia become pregnant not because their contraception fails but rather because they are not using contraception.

Repeat abortions

The majority of women receiving abortions in British Columbia are doing so for the first time, and hence do not appear to be using abortion as their main ongoing method of birth control. However, 27 percent (2,924) of those getting abortions in 1985 had had at least one abortion previously--the second highest rate of repeat abortions in the country. Just over 5 percent (596) had already had two or more abortions.

During the past several years, the number of women having repeat abortions has risen quite steadily. All observers agree, however, that this is due mainly to the fact that since 1969 the Province has had a growing number of women who have had a first legal abortion and are therefore at risk of having a repeat abortion. This trend does not necessarily signify any shift from contraception to abortion as a means of fertility regulation; indeed, the experience of other countries which have undergone a liberalization of abortion laws suggests that the number of repeat abortions should gradually plateau.

Age and marital status

Unlike countries such as Hungary and Czechoslovakia, where abortion is used mainly (and sometimes repeatedly) by married women over the age of 25 in order to limit family size, abortion in British Columbia is most common among young, single women who do not yet have families. In British Columbia, repeat abortions among older women are relatively infrequent because once couples have completed their families they are likely to choose some form of surgical sterilization.

Overall assessment

It appears that, while some women may resort to abortion because they have failed to use contraception, this is not a practice which most repeat. The majority of women obtaining an abortion in British Columbia are using the abortion to terminate a single unplanned pregnancy outside of marriage. They are not relying on abortion as their primary, ongoing method of family planning.

4.8 Health Implications of Abortion

How safe for the woman is a therapeutic abortion?

Relative complication rates

Most abortions performed in hospitals by qualified professionals during the first trimester of pregnancy carry little medical risk. In fact, the risks associated with an early abortion are less significant than those associated with continued pregnancy and childbirth. A second trimester abortion has a somewhat higher complication rate than a first trimester abortion, but is still a very safe procedure.

Mortality

From 1963 to 1967, before therapeutic abortion was legalized, the average annual number of deaths resulting from abortions in Canada was 4.0. During the most recent period for which we have statistics, from 1976-1982, the average annual number of deaths was 0.0.

Psychological Risks

Early studies of women receiving abortions suggested that these patients might experience long term psychological problems as a result of the procedure. More recent studies indicate that, while abortion commonly causes women some degree of emotional distress, it is not psychologically harmful for most women in the long term, and frequently the main response is a feeling of relief.

4.9 Access to Abortions

Are there undue obstacles to obtaining an abortion in some or all regions of British Columbia? If so, why?

Regional variations

There is a considerable variation in the availability of abortion services from one region to another and from one town to another. This is because:

- Under the Criminal Code, hospital boards are not obliged to appoint therapeutic abortion committees, and some choose not to.

- Different therapeutic hospital committees define the terms of the Criminal Code in different ways. Some define a threat to the woman's health very narrowly, perhaps permitting an abortion only where her physical health is seriously jeopardized. Others define a threat to the woman's health very broadly, to encompass temporary anxiety or even "social" health.

Impact of regional variations

The inconsistency in abortion policies among hospitals means that some women travel considerable distances to obtain abortions. It also means that those hospitals which do perform abortions often end up accepting patients from those areas where abortions are not available.

Time required for approval of abortions

The Ministry's review team found that applications for therapeutic abortions are handled relatively promptly by most therapeutic abortion committees; that the approval process does not result in undue delays in performing necessary abortions. In most cases, an abortion application is approved, and the abortion performed, within 14 days.

4.10 Conclusions

Therapeutic abortions in British Columbia are being performed in compliance with the Criminal Code of Canada, and most women obtaining them are not using them as their primary form of family

planning. A therapeutic abortion is a relatively safe procedure for most women, with few physical or psychological risks. With the exception of a small increase in 1986, the rate of abortion has generally been declining during the past several years. Nevertheless, it is still higher than in most other parts of Canada, particularly among single women in their twenties. It is not completely clear why British Columbia's rate is higher than those of other provinces. Since most abortions terminate pregnancies which were never wanted, rather than pregnancies which were originally wanted but subsequently became a danger to the woman's health, most should also be preventable. Therapeutic abortion committees in British Columbia generally permit abortions in order to protect the physical, mental, or social health of a woman, and approve the great majority of applications they receive. But a few therapeutic abortion committees interpret the Criminal Code more narrowly and, as a result, there is considerable variation in the availability of abortion services from one region to another.

5.0 FINDINGS RESPECTING CURRENT ARRANGEMENTS FOR THE CONTINUATION AND PREVENTION OF UNWANTED PREGNANCIES

5.1 Introduction

Therapeutic abortion is only one aspect of the larger issue of unwanted pregnancy. Abortion is an unattractive option for dealing with an unwanted pregnancy--one selected when the apparent alternatives are perceived to be even less desirable. This section examines the current status of policies and programs which deal with those alternatives:

1. a woman's continuation of an unwanted pregnancy in order to (a) keep and the rear the child herself, or (b) relinquish the child for adoption; and

2. avoidance of unwanted pregnancy in the first place.

5.2 Support Services for Expectant and Single Mothers

Services Available

Continuing an unwanted pregnancy, either to give a baby up for adoption or to keep it, can entail significant financial sacrifices, as well as emotional and social stresses. Current public policies do offer some buffers against these difficulties: For example:

- The Employment Standards Act requires employers to permit unpaid maternity absences of up to 18 weeks.

- Unemployment insurance is available for 17 weeks for maternity leave.

- For those with low incomes, the Ministry of Social Services and Housing provides financial assistance of up to $691 per month for unemployable women (those with one child under the age of 6 months or two under the age of 12 years), plus a "natal" allowance of $25 per month for six months before and six months following the birth of a child.

- Social Services and Housing also offers subsidies for day care, and funds a variety of employment and educational assistance programs for which single mothers could be eligible.

Potential Problem Areas

Nevertheless, expectant and new mothers, living alone and without an established career or other independent source of income, face a number of serious problems. Awareness of these problems may deter some single women from continuing unplanned pregnancies. The most obvious difficulties include:

- Financial problems. Women under the age of 19 are not eligible for income assistance. Unless they have been married, they are expected to turn to their parents for help. The current assistance rates for single parents who are eligible have increased little since 1982, and likely provide a very meagre existence. Furthermore, it can be very difficult to find day care for infants under the age of three and, even for children over three, the current day care subsidies normally fall far short of actual expenses.

- Residential problems. Young, pregnant women without husbands or families to offer emotional and financial support may need a "safe haven" during their pregnancies but be unable to find one. Traditional "homes for unwed mothers" are not used as much as as they were a couple of decades ago. Only two such facilities are still in existence: one in Kamloops, with 11 beds; and one in Vancouver, with 15 beds. Social Services and Housing provides per diem payments to these homes for beds occupied by pregnant women needing such services. The demand for this type of service is apparently low, as these two facilities are never filled to capacity. What may be needed are innovative programs capable of providing unwed, expectant mothers with a comprehensive set of support services in modern and pleasant surroundings.

- Educational problems. Some communities have made special arrangements so that pregnant teenagers can continue their schooling (e.g. "Options," in Victoria); but in other communities an unintended pregnancy can seriously, and perhaps permanently, disrupt a student's career.

5.3 Adoption Services

Types of Adoption

At present, adoption can be arranged either through the Ministry of Social Services and Housing or privately. Where Social Services and Housing is involved, adoptive parents are carefully screened and no direct contact is permitted between them and the birth mother. Private adoptions can occur directly, by the birth mother making arrangements with the adoptive parents of her choice. Alternatively, an intermediary, often a doctor or a lawyer who knows both parties, may be involved. The only requirement in private adoptions is that the Superintendent of Child Welfare conduct an inquiry and make a recommendation to the Supreme Court with respect to whether or not an adoption order should be granted.

Numbers and Trends

The number of children put up for adoption to non-relatives through both Social Services and Housing and private arrangements has dropped dramatically since the early 1970s: from a high of 1,993 in 1970/1971, to just 527 in 1985/86. Of the 407 children placed by Social Services and Housing in 1985/86, 116 were classified as healthy Caucasian infants--i.e. they were children under two years of age without handicaps or special needs. The remaining 291 children were older than two, or had special needs of some kind.

During the 1960s, it was not possible to find homes for all of the children relinquished for adoption. In contrast, the Ministry of Social Services and Housing currently places only 10 to 11 "healthy" infants per month, while maintaining a long waiting list of homes seeking to adopt such children--about 250 already approved; 400 in the process of being assessed; and another 1500 waiting to be assessed.

The smaller supply of children is likely due to at least two changes which have occurred in the past 15-20 years: (1) the greater availability of legal abortion, and (2) greater social acceptance of single motherhood. The Ministry of Social Services and Housing estimates that, at present, only 5 to 10 percent of infants born out of wedlock are relinquished for adoption, whereas before 1970 this occurred in 85 percent to 90 percent of such cases.

Possible Obstacles to Adoption

The factors determining a woman's decision to (1) have an abortion, (2) raise an initially unwanted baby herself, or (3) give a baby up for adoption are not well documented. What is clear, however, is that the popularity of adoption has declined dramatically relative to the other options, not just in British Columbia but in other jurisdictions as well. A preliminary review has uncovered some aspects of the current adoption system which may hinder or discourage women from considering adoption. These include:

- <u>A lack of information about adoption</u>. Adoption procedures may not be sufficiently well known among physicians, counselling agencies, school counsellors, or even government staff. Social Services and Housing has developed a good brochure aimed at women considering adoption, but it has not been circulated beyond the Ministry's own offices and may not even be available in all of them.

- <u>The "closed" nature of the current procedures</u>. Some women may find it difficult to proceed with an adoption under the auspices of Social Services and Housing. The Government's decision to introduce a disclosure registry for the use of adult adoptees will provide a mechanism to reunite birth mothers with adult children given up for adoption as infants. This may make adoption more attractive to some mothers.

Privately arranged adoptions have become increasingly popular in recent years: 38 were completed in 1970/71, 120 in 1985/86.

- A lack of emotional support for the birth mother. Most of the counselling now available is focussed on the pre-adoption period, whereas women may experience some form of emotional distress for prolonged periods after giving a child up for adoption.

5.4 Prevention of Unwanted Pregnancies

General

British Columbia does not have a coordinated program to prevent unwanted pregnancy. No agency at the Provincial level has taken the lead role with respect to this issue. Instead, individual Government programs, along with voluntary groups and local agencies, address specific aspects of the issue on an ad hoc basis.

Family life education

The Premier announced recently that, by next fall, the Ministries of Education and Health will develop a Province-wide family life education program for schools. In the past, the decision on whether or not to provide family life education, including guidance and information with respect to the prevention of pregnancy, has been up to individual school districts. School districts which chose to implement such programs developed their own curriculums. Last summer, the Ministry of Education circulated "A Handbook for Family Life Education (1986)" to school districts, but this was a resource manual, not a curriculum guide. Since existing programs have been developed and implemented locally, the Ministry of Education does not have precise information about how many exist or what subjects they cover.

Family planning services

The Ministry of Health does not have a program aimed specifically at promoting family planning or the prevention of unwanted pregnancy. Public health nurses provide contraceptive counselling upon request, as well as in pre-natal and post-natal classes. In addition, they are often invited to speak to school sex education classes.

Most family planning services in British Columbia are provided by general practitioners and voluntary associations. For example, one family planning agency has 15 clinics around the Province. In addition to contraceptive counselling, these clinics offer: educational programs designed to encourage responsible sexual behavior; counselling to women with unwanted pregnancies; and contraceptive supplies to persons who cannot afford to purchase them. Except for Medical Services Plan payments for the physicians working in such clinics, the Ministry of Health provides no financial support; non-medical staffing is largely voluntary.

The Ministry of Social Services and Housing will also pay for contraceptive supplies for those income assistance recipients eligible under the Guaranteed Available Income for Need Act for special medical coverage (e.g. unemployable persons).

5.5 Conclusions

Existing public policies do provide support to women who decide to continue unwanted pregnancies, but there are several apparent deficiencies. Financial assistance to single parents provides a minimal standard of living, and adoption arrangements may seem overly restrictive to women wanting to be reassured about the placement of their babies. To date, the Province has also lacked a comprehensive program to prevent unwanted pregnancies.

6.0 POLICY NEEDS AND CONSTRAINTS

6.1 Policy Needs

Earlier sections of this paper examined existing arrangements for the handling of all aspects of unwanted pregnancies, including their prevention, continuation, and termination. This examination revealed that our current approach to this issue may be inadequate in a number of ways; that the Government may not be doing all it could to achieve the policy goals of minimizing the demand for abortion and ensuring that the supply of abortion services is appropriate.

More specifically, the following policy/program weaknesses were identified with respect to each of the Government's two broad goals:

1. Goal: Minimize the demand for abortion by supporting alternatives

   Apparent policy/program weaknesses:

   - The Province has not shown strong leadership with respect to the avoidance of unwanted pregnancies. Family life education programs are not available in all school districts, and family planning services have been left largely to private agencies.

   - Support services available to expectant and single mothers are significant but appear to have a number of weaknesses which may deter women from continuing with unwanted pregnancies.

   - Adoption services are not well publicized and may be too restrictive to be attractive to some women.

2. Goal: Prevent oversupply/undersupply of abortion services

   Apparent policy/program weaknesses:

   - Abortion services in British Columbia are in all cases being supplied in accordance with the Criminal Code, and there is no evidence that women are obtaining them as an ongoing method of family planning or at serious risk to their own health. However, there are considerable regional variations in supply because different therapeutic abortion committees have different interpretations of the Criminal Code--especially with respect to when a pregnancy endangers a woman's health. Hospitals that are more prepared than others to supply abortions tend to attract unwieldy abortion workloads while those with restrictive policies have very small workloads.

   - Therapeutic abortion committees have been provided with no guidance on many of the key decisions they must make, and are frequently vilified for being either too lenient or too restrictive.

6.2 Policy Constraints

Any discussion of provincial government initiatives with respect to abortion and unwanted pregnancy must recognize that there are some important practical limits on what the Province can in fact do in this area.

These limits include:

1. Legal Constraints. The responsibility for abortion law lies within federal jurisdiction, and the Federal Government has chosen to delegate a considerable amount of discretion regarding abortion decisions to the therapeutic abortion committees of individual hospitals. Any steps taken by the Provincial Government with the predominant effect of making the Federal law more restrictive would be beyond the authority of the Provincial Legislature and hence subject to legal challenge and invalidation. For the most part, therefore, any Provincial efforts to influence the demand for, or supply of, abortion services will have to take the form of incentives, not sanctions. Consequently, the Government should have realistic expectations about the extent, and especially the timing, of any changes to the abortion rate which may result from Provincial action. Major reductions are unlikely to occur overnight.

2. Financial Constraints. Because of the need to limit the overall level of government spending, any program or policy initiatives must be affordable. Supporting alternatives to abortion in a major way could involve substantial new expenditures; reducing the supply of legal abortions could increase medical and social services costs or even endanger transfer payments from the Federal Government.

3. Social Constraints. Abortion is an emotional issue for many citizens. Changes may not be appropriate if they erode even further the shaky measure of social consensus that still exists. Public opinion polls generally seem to show that there is not an overwhelming preponderance of opinion in favour of changing the operation of the existing abortion law one way or the other. In June 1985, a survey conducted for The Globe and Mail by a Montreal-based polling organization found that 53 percent of Canadians surveyed agreed, and 41 percent disagreed, with the statement, "Every woman who wants an abortion should be able to have one." The proportion of persons agreeing with the statement in British Columbia was slightly higher than the national average--59 percent. Surveys of this type are, of course, open to a variety of interpretations.

7.0 OPTIONS TO SUPPORT ALTERNATIVES TO ABORTION

7.1 Introduction

In essence, there are two types of action the Provincial Government could take in an effort to ensure that no unnecessary abortions are performed. These are: (1) steps to influence demand: i.e. minimize the demand for abortion by ensuring that attractive alternatives are available, and (2) steps to to influence supply: i.e. discourage oversupply (or undersupply) of abortion services. This section discusses a number of sub-options within the first broad approach; section 8.0 does likewise for the second approach.

7.2 Option 1: Introduce Programs to Prevent Unwanted Pregnancies

Description

Initiatives in this area could involve:

1. Introduction of family life/sex education programs in all schools. These programs could include the following components: (a) assertiveness and decision-making training designed to assist teenagers to delay sexual activity; (b) information about the most effective means of contraception; (c) information about pre-natal development and abortion; and (d) materials and advice for parents, to help them provide guidance to their children.

2. Funding of family planning clinics in most communities. The Ministry of Health could offer these services directly, through its public health units. Alternatively, the Ministry could provide funding to private organizations and societies such as those which already exist in some communities. Community clinics of this type could offer contraceptive and pregnancy counselling, and provide contraceptive supplies free of charge to those in financial need.

Advantages

- The Government has already announced its intention to introduce a school sex education program next fall.

- Studies from other jursidictions (including the United States and Sweden) contain considerable evidence showing that public preventive programs are associated with declining pregnancy rates and ultimately with declining abortion rates. A major study on adolescent pregnancy completed last year in Ontario found "the combination of BOTH education and public health contraception clinics is associated most consistently with effective prevention."

Disadvantages

- School-based educational programs should be a good strategy for reducing teenage pregnancy rates, but they will not have an immediate impact on the women currently having the greatest numbers of abortions--women in their twenties.

- While strongly recommending aggressive public education about contraception and improved access to contraceptive supplies for adolescents, a study on teenage pregnancy released in January by the U.S. National Academy of Sciences suggested that the ultimate solution to the problem of unwanted pregnancies among young women may lie in changing their self-perception and life expectations. Young people who feel that they have bright educational and occupational futures find it easier to resist risky activity of all kinds, including sex, and they are more likely to take precautions to minimize the risks if they do become sexually active. (Such fundamental attitudinal changes, the study acknowledges, are long term goals, subject to the achievement of major social and economic reforms [e.g. greater educational and employment opportunities and the elimination of poverty].)

7.3 Option 2: Improve and Publicize Adoption Process

Description

This could involve:

1. Efforts to make the adoption alternative more widely known to pregnant women. This would involve an information program designed to: (a) increase awareness of the adoption services available through Social Services and Housing; and (b) explain the steps involved in completing an adoption privately. A program of this type should be aimed at physicians, clergymen, pregnancy counsellors, and the general public.

2. Changes to existing adoption procedures. These changes would be designed to make adoption more palatable to women thinking of giving up their babies. For example, new procedures might allow some controlled contact between the woman and the adoptive parents, and will soon involve the establishment of a "registry" to permit birth parents and adoptees to find each other in later years if both so wish.

3. More comprehensive support programs for women choosing adoption. This could entail counselling and financial assistance, both before and after the birth of the child.

Advantages

- There appears to be a lack of information about adoption among many key service providers, such as physicians.

- Existing adoption procedures have already been identified as needing to be reviewed and updated.

- Government may not have been showing enough leadership in this area, i.e. making it plain that giving a child up for adoption is to be viewed as a socially acceptable and responsible course of action for a woman with an unwanted pregnancy.

Disadvantages

- Virtually no research has been done on the factors which affect the decision of women to place their children for adoption. In 1981, the U.S. Congress passed legislation mandating efforts to make adoption more attractive but, so far, little is known about the types of services which may be needed/effective.

- Where declines in abortion rates have been documented, these appear to have resulted from prevention of pregnancy rather than from women switching from abortion to adoption.

7.4 Option 3: Enhance and Publicize Support Programs for Expectant and Single Mothers

Description

This could involve:

1. Better pregnancy counselling services. This could be accomplished through direct expansion of Ministry programs or by offering additional incentives/funding to private practice physicians and interested groups.

2. Increases in the level of financial support available to single mothers.

3. More generous day care subsidies.

4. Expansion of educational programs (and, if a demand can be demonstrated, residential programs) available to expectant mothers. Such programs could be available to any woman planning to continue an unplanned pregnancy, whether to keep the child or give it up for adoption.

5. Better coordination of existing programs. A single point of access and comprehensive "case management" could make the prospect of locating the necessary services considerably less daunting.

6. Better enforcment of maintainance payments from fathers. The Province could strengthen its efforts to ensure that fathers provide support as required by the Family Relations Act and Child Paternity and Support Act.

Advantages

- The assurance that continuation of an unexpected pregnancy would not result in undue interruption of their schooling or a lifetime of poverty might make it easier for some women to consider this option.

- By reducing the practical difficulties associated with unwanted pregnancy, such programs might also reduce the social and psychological trauma experienced by women with unwanted pregnancies, thus making some of these pregnancies less of a health hazard in the eyes of both women and therapeutic abortion committees.

Disadvantages

- To be effective, better financial assistance would probably have to be available on a long term basis, not just for a few months before and after the child's birth. Since there are presently about 35,000 single parent households receiving income assistance, significant rate increases could prove very costly for the Provincial Government. The effect would be even greater if the higher rates inadvertently served as an incentive for some women to get pregnant.

- Providing higher levels of financial support for single mothers raises significant and difficult questions of social policy: does the Government wish to favour this group over others in need--e.g. the handicapped?

- A U.S. study found little empirical evidence to indicate that income assistance benefit levels affect decisions about pregnancy, abortion, childbearing, or adoption.

- Encouraging women to keep children they do not really want may exacerbate social problems such as child abuse.

- A number of studies suggest that women obtaining abortions come disproportionately from higher socio-economic groups. Thus financial consideration may be a relatively small consideration for many of the women having abortions.

7.5 CONCLUSIONS

There is a wide variety of initiatives which the Province could take in order to provide better support for alternatives to abortion. Of these, the most promising by far appears to be the prevention of unwanted pregnancies through (1) family life education in schools, and (2) convenient, confidential, and inexpensive family planning services in the community.

8.0 OPTIONS TO PREVENT OVERSUPPLY/UNDERSUPPLY OF ABORTION SERVICES

8.1 Introduction

The second group of options available to the Government relates more directly to abortion but it is also an area where the Government's freedom of action is severely circumscribed. Under the Criminal Code, most authority relating to the supply of abortions has been assigned by the Federal Government to hospital boards and therapeutic abortion committees.

8.2 Option 4: Lobby Federal Government to Modify the Abortion Law

Description

British Columbia could ask other provinces to join in lobbying the Federal Government for amendments to the Criminal Code. Among the amendments which could be sought would be a suitable interpretation of the phrase "would or would be likely to endanger her life or health."

Advantages

A strong lobbying effort by the provinces would place pressure on the Federal Government to eliminate some of the vagueness in the current law. This, in turn, might alleviate some of the confusion and inequities created by differing regional interpretations of the existing provisions.

Disadvantages

Unless the provinces could demonstrate a broad measure of public support for their proposed modifications, it is unlikely that the Federal Government would be willing to alter the status quo.

8.3 Option 5: Increase Auditing of Therapeutic Abortion Committees

Description

The authority of the Provincial Minister is Health is very limited under the existing provisions of the Criminal Code. The Minister is entitled, however, to require a therapeutic abortion committee to provide him a copy of any certificate of approval issued by that committee, "together with such other information relating to the circumstances surrounding the issue of that certificate as he may require." This information could conceivably relate to matters such as reasons for approval, timing of approval, and procedures associated with approval.

Advantages

- It would signal to hospitals that the Government does not want abortions to be "trivialized" and that the abortion law must be administered meticulously.

Disadvantages

- It would not directly reduce the number of abortions.

- It might antagonize physicians serving on therapeutic abortion committees, who could feel that the Government was inappropriately analyzing or "second guessing" their medical judgement.

8.4 Option 6: Develop Model Guidelines and Approval Criteria for Therapeutic Abortion Committees

Description

The Province could provide hospitals and therapeutic abortion committees with voluntary/suggested guidelines on a wide variety of issues related to abortion. These guidelines could address issues such as: (1) the circumstances in which hospital boards should consider establishment of a therapeutic abortion committee (e.g. to meet an "undersupply" problem in a certain region or to ensure an appropriate distribution of workload among hospitals in an urban area); (2) the interpretation of "health" for the purposes of section 251 of the Criminal Code; (3) documentation to be completed respecting each abortion application; (4) the conduct of meetings and interviews with applicants; (5) consent procedures; (6) the provision of counselling to the applicant; and (7) gestational limits for abortions. In essence, this would constitute a refinement and expansion of guidelines issued to hospitals in 1970, following amendment of the abortion law.

The Ministry of Health could develop guidelines itself, or it could strike a "blue ribbon" panel to address some of the key philosophical/ethical issues such as definitions of "health" and gestational limits. With the proper composition (e.g. physicians, clergy, ethicists, lawyers, health administrators, women's groups, and others), such a panel might provide an effective forum for developing a greater degree of consensus on some of the difficult issues relating not only to abortion but also to other troubling ethical dilemmas in the field of health care--e.g. euthanasia, living wills, genetic engineering, and the use of human embryonic tissue for scientific purposes.

Advantages

- Because they would be voluntary, guidelines would not constitute an intrusion by the Provincial Government into responsibilities assigned to therapeutic abortion committees.

- Guidelines might help to standardize the criteria for approval of abortions around the Province, thus making access more equitable (guidelines could help to address examples of undersupply as well as of oversupply).

- Centrally developed guidelines would divert controversy away from physicians and hospital boards, and allow them to concentrate on quality health care.

Disadvantages

- Guidelines might not have any effect at all since therapeutic abortion committees would be free to ignore them.

- Groups believing in a liberal interpretation of the World Health Organization definition of health would likely criticize any guidelines as being too restrictive; groups committed to limiting the number of abortions might consider them too lax.

8.5 Option 7: Prescribe Compulsory Procedures for Therapeutic Abortion Committees

Description

The Government could attempt to prescribe conditions which must be met before abortions may be performed in the Province's hospitals. These conditions could pertain to matters such as consent documents, counselling programs, minimum size of the hospital or medical staff, or length of gestation.

Advantages

- Consent requirements could make women reexamine their need for abortion; counselling services might minimize the likelihood of women having repeat abortions.

Disadvantages

- It is not at all clear that the Province has the legal authority to prescribe procedures such as these. Although the Canadian Health Facilities Law Guide (1984) states that the Province does have the right to set some rules respecting the conduct of abortions in hospitals, a 1985 court decision in Saskatchewan held that the provincial government could not institute procedures (such as extensive consent requirements), the "pith and substance" of which was to make the criminal law (a Federal responsibility) more restrictive.

8.6 Option 8: Eliminate Medical Coverage for Some Abortions

Description

The Medical Services Plan could cease paying for therapeutic abortions except where it deems them to be "medically necessary."

Advantages

- This action would make it plain that the Government does not condone abortion except in the most serious of circumstances.

- The Government could justify the change by pointing to similar limits on M.S.P. payments in other areas.

- It might help to satisfy critics who object to public subsidization of abortions they consider elective or frivolous.

- Since the Province would not be preventing abortions deemed "non-essential," but simply refusing to pay for them, it would not be intruding into the area of criminal law. It is conceivable that such a payment policy could be challenged on the grounds that its effect was to restrict the Federal law, but it is unlikely that such an action would succeed.

- The Province would presumably save some portion of the $3.2 million per year currently paid by the Medical Services Plan for abortions, as well as at least some hospital costs.

Disadvantages

- The Province would have to develop a definition of "medical necessity." This would be extremely controversial: some critics would consider the definition too narrow, others would call it too wide.

- The Medical Services Plan would have to establish a separate mechanism for determining whether or not individual abortions were medically necessary for the purposes of medical insurance, since this determination might well differ from that made by therapeutic abortion committees for the purposes of the Criminal Code.

- If the interpretation of the Canada Health Act which has been used until now is correct, Federal cost sharing could be jeopardized. The Canada Health Act states that if a province fails to pay for "medically necessary" services, the Federal Government may withhold cost sharing. Arguably, an abortion is being designated as "medically necessary" when a therapeutic abortion committee composed of not fewer than three medical practitioners certifies

that failure to perform the procedure would, or would likely, endanger the life or health of the woman.

- The change would be discriminatory because it could present a major barrier for poor women seeking an abortion but would not have a significant effect on wealthier women.

- The number of late abortions might increase if women had to find money before having the operation. Late abortions are accompanied by a rise in morbidity and mortality and by increasingly difficult moral and ethical judgements for most physicians and women.

- The number of illegal abortions might rise, resulting in higher morbidity and mortality, and ultimately costing the Province more money than the Medical Services Plan would save by not paying for legal abortions.

- It is not clear how many abortions would be prevented. Since 1977, the U.S. Federal Government has refused Medicaid claims for abortions provided to low-income women for other than life-saving reasons. A study conducted in 1980 concluded that 80 percent of the women denied a Medicaid abortion eventually raised the money for a private abortion, while 20 percent gave birth.

As an alternative to eliminating medical coverage for some abortions, the Government could consider reducing the amount paid to doctors for performing abortions. This could signal the Government's desire to discourage any unnecessary abortions.

8.7 Option 9: Appoint Hospital Boards Committed to Limiting Abortions

Description

Under the Criminal Code, the decision on whether or not to appoint a therapeutic abortion committee rests with a hospital's board of management. Under the Hospital Act, the Provincial Government has the power to alter the composition of hospital boards or to appoint public administrators; by taking such action, the Government could theoretically ensure that hospitals either dismissed their therapeutic abortion committees or appointed committees favouring a restrictive approach to the approval of abortions.

Advantages

- This would be the most direct way for the Government to reduce the supply of legal abortions in British Columbia.

- It appears unlikely that such action would intrude into the domain of criminal law or endanger cost sharing under the Canada Health Act.

Disadvantages

- It would produce vociferous opposition from groups which believe in a liberal interpretation of the World Health Organization definition of health, and also from most of the medical profession.

- Reduced access to hospital abortions would probably increase the demand for free standing abortion clinics.

- If the overall supply of abortions in British Columbia were reduced, most women refused abortions might simply obtain them in the United States. In addition, it would almost certainly lead to the re-introduction of illegal abortions, with the consequences described under the previous option.

- "One-issue" hospital boards may not have the skills to manage hospitals effectively.

8.8 Conclusions

There is a wide spectrum of options available to the Government to influence the supply of abortions. These range from voluntary guidelines to the appointment, at all hospitals, of boards of trustees committed to limiting the number of abortions. Because of the likelihood of serious medical, financial, and political repercussions from any efforts to forcibily reduce the supply of legal abortions, voluntary measures are far more attractive.

9.0 RECOMMENDATIONS

In order to reduce the demand for abortions, the Government should take steps to support the alternatives. Specifically:

1. Develop better educational and contraceptive programs to prevent unwanted pregnancy.

   In addition to family life education programs in all schools (an initiative already being planned), this should involve a network of convenient family planning clinics throughout the Province.

   - Such clinics could be established in conjunction with public health units (this would require an increase in staffing, including physicians, nurses, and social workers).

   - In other communities, the Ministry of Health could provide funding to private organizations.

   Programs to prevent unwanted pregnancy appear to be the most cost effective approach available to the Province and should therefore receive the highest priority and the largest budget allocation.

2. Promote greater awareness of the alternatives to abortion.

   This should involve:

   (a) An information campaign aimed at providing physicians, government staff, clergymen, and private organizations with a good understanding of all of the options and services currently available to women with unwanted pregnancies.

   (b) The development of incentives to encourage doctors to offer extended counselling (or to make appropriate referrals for extended counselling) to women experiencing unwanted pregnancies.

   - Such counselling should deal with: (i) alternatives to abortion, in the case of women who currently have unwanted pregnancies, and (ii) family planning and contraception, in the case of women who have recently had an abortion.

   - To give the subject prominence in the minds of physicians, incentives might take the form of a special fee item.

   - In addition, hospitals could be asked to encourage abortion patients to arrange follow-up visits with their family physicians, gynecologists, or public health units soon after the procedure.

(c) Government funding for pregnancy counselling centres operated by public health units or by private organizations.

(d) The development of coordinating/case management services to help women understand and access alternatives to abortion, including adoption and financial/emotional support services.

- This might involve toll-free "hot lines" for women in rural areas.

3. Where possible, offer additional assistance to women continuing their pregnancies.

On an immediate basis, this could involve:

(a) Improved access to special programs to enable pregnant teenagers to continue their schooling.

(b) Better enforcement of maintenance payments from fathers.

(c) The provision of additional financial assistance for privately operated homes for unwed mothers, if there is a demonstrated demand for such services; or, alternatively, the development of pilot projects to test out innovative forms of residential support for expectant mothers--e.g. sheltered independent apartments.

On a longer term basis, this could involve increases in social assistance rates and day care subsidies, as well as improvement of adoption procedures.

In order to prevent either an oversupply or an undersupply of abortion services (and avoid inconsistency in the application of the abortion law), the Government should take the following steps:

4. Establish a blue ribbon panel of medical and ethical experts to develop voluntary, public guidelines for hospital boards and therapeutic abortion committees.

These guidelines should include a definition of the phrase "would or would be likely to endanger her life or health." Ideally, the guidelines should be developed by a "Special Panel on Ethical Issues in Health Care"--a body which could also address issues such as euthanasia, genetic engineering, and the use of human embryonic tissue for scientific purposes.

5. Institute regular auditing of the activities of therapeutic abortion committees.

6. Urge the Federal Government to review and amend the Criminal Code provisions relating to abortion.

   The Province should suggest that the Federal Government (a) clarify conditions under which abortions may be permitted, by defining the phrase "would or would be likely to endanger her life or health"; and (b) reexamine the concept of "therapeutic abortion committees," to determine whether or not these bodies are performing any useful function, or whether some better mechanism for overseeing the supply of abortions could be developed.

It is not recommended that the Government take strong restrictive action to limit or reduce the overall supply of abortion services (e.g. the appointment of hospital boards committed to limiting the number of abortions, or the elimination of medical coverage for some abortions). Although such action might have a significant immediate impact on the total number of legal abortions performed, it could also have extremely serious medical, financial, and legal side effects.

Schedule A outlines the estimated 1987/88 costs of implementing the recommendations contained in this report.

SCHEDULE A

PREVENTION AND HANDLING OF UNWANTED PREGNANCIES

1987/88 BUDGET REQUIREMENTS

1.	Recommendation #1: Educational and Contraceptive Programs	
	a. Needs assessment to determine current service gaps	$50,000
	b. Staffing costs for public health units and/or funded agencies	$630,000
	c. Materials and supplies	$150,000
	d. Ministry coordinator	$45,000
2.	Recommendation #2: Promote Awareness of Alternatives to Abortion	
	a. Information program for health and social services professionals; and public media campaign	$300,000
	b. Toll-free information and referral line	$150,000
3.	Recommendation #3: Additional Assistance for Pregnant Women	
	Will include innovative pilot projects designed to provide services identified as necessary by needs assessment and community groups (e.g. sheltered independent apartments)	$500,000
4.	Recommendation #4: Blue Ribbon Panel	
	Travel expenses and per diems	$20,000
5.	Recommendation #5: Audit Therapeutic Abortion Committees	nil
6.	Recommendation #6: Urge Federal Government to Amend Criminal Code	nil
TOTAL		$1,845,000